IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

April 23, 2008

Jill Garrett
Hands Of Hope Hospice
1379 East 17th Street
Idaho Falls, ID 83401

Dear Ms. Garrett:

On **February 19, 2008,** a Complaint Survey was conducted at Hands Of Hope Hospice. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003284

Allegation #1: Hospice services were provided to a patient who was not eligible for hospice care.

Findings: An unannounced visit to the hospice was made on 2/14/08 in order to investigate the complaint. During the investigation, agency policies as well as 20 clinical records were reviewed. Staff were interviewed.

All clinical records contained signatures of the patients' attending physicians and Hospice Medical Director certifying the patients as having a terminal illness with a prognosis of less than 6 months to live. All of the clinical records contained documentation of recertification of terminal illness by the Medical Director at the required time frames. A form was used document this. 42 CFR Part 418, Conditions of Participation for Hospice Agencies, does not list the criteria by which this is determined. The regulations only require that the appropriate physicians certify the patient's eligibility. This requirement was met. Surveyors did question the appropriateness of some current patients to receive hospice services. These patients' records were forwarded to the Centers for Medicare and Medicaid Services for further review. The record of the patient noted in the complaint appeared appropriate for hospice care and was not among the records forwarded.

The agency was in compliance with Medicare certification regulations. While the appropriateness of some patients to receive hospice services was questioned, it is beyond the authority of this office to decide whether the patients were, in fact, inappropriate for hospice services. Therefore, insufficient evidence exists to substantiate the allegation.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The Hospice agency failed to discontinue medications as requested by a patient's family.

Findings: One record contained documentation that a patient's family was concerned that a patient's physical decline may have been caused by an anti-anxiety medication the patient was taking. A "Nursing Interim Note", dated 8/31/07, documented the Hospice Agency held a meeting with family members to discuss their concerns. The record contained an order, dated 8/31/07, to discontinue the anti-anxiety medication at the family's request. Nursing notes, dated 9/3, 9/5, and 9/6/07, documented the patient had increased anxiety and was started on a different anti-anxiety medication on 9/6/07. Nursing notes, dated 9/7 and 9/13/07, documented the patient's anxiety had decreased after the medication was started. Additional nursing notes documented the Hospice staff continued to monitor the patient's level of anxiety.

On 2/14/08 at 11:00 AM, the Administrator, who was an RN and had provided care to the patient, stated the anti-anxiety medication had been discontinued on 8/31/07 at the family's request. She said the patient's anxiety increased after the medication was discontinued and she was started on another anti-anxiety medication on 9/6/07, after a discussion with the person who was designated as power of attorney for the patient. The Administrator stated the patient's anxiety decreased after she was started on the new medication.

On 2/14/08 at 1:44 PM, the Social Worker stated the patient was often anxious and the medication reduced her anxiety. She said the patient's anxiety increased after her husband died in July 2007. Additionally, she stated the patient did not appear to be over sedated.

No issues related to the inappropriate prescription of medications were identified in 7 other patient records reviewed. No deficiencies were cited.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: A Hospice patient was unable to communicate in English and the agency failed to provide translation services to ensure they were meeting the patient's needs.

Findings: One patient's record contained documentation, that although she could understand and speak English she would, at times, speak in her native language. Social Worker notes, dated 9/17, 9/14 and 9/7/07, documented that, when the patient had increased anxiety, her speech became rapid and difficult to understand.

On 2/14/08 at 1:44 PM, the Social Worker stated the patient would speak in her native language when she was anxious but would communicate in English when she was calm. She stated the patient was able to communicate her needs to the Assisted Living and Hospice staff.

On 2/14/08 at 3:55 PM, the Administrator, who was an RN and had provided care to the patient, stated the patient was able to understand and communicate in English. She said that, as the patient physically declined, she would frequently revert to her native language but could still verbally express her needs. Both the Social Worker and the Administrator stated they were able to communicate with the patient and elicit appropriate responses. No other patients with language issues were identified. No deficiencies were cited related to this. During the investigation, however, deficiencies unrelated to the complaint were identified and cited at 418.68 Condition of Participation for Interdisciplinary Group.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

RAE JEAN MCPHILLIPS
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

RJM/mlw

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CERTIFIED MAIL: 7000 1670 0011 3315 2061

March 4, 2008

Jill Garrett
Hands of Hope Hospice
1379 East 17th Street
Idaho Falls, Idaho 83401

RE: Hands of Hope Hospice, provider #131547

Dear Ms. Garrett:

Based on the survey completed at Hands of Hope Hospice on February 19, 2008 by our staff, we have determined that Hands of Hope Hospice is out of compliance with the Medicare Hospice Conditions of Participation on Interdisciplinary Group (42 CFR 418.68). To participate as a provider of services in the Medicare Program, a Hospice must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused this condition to be unmet, substantially limit the capacity of Hands of Hope Hospice to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance. Such corrections must be achieved and compliance verified, by this office, before **April 4, 2008. To allow time for a revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than March 27, 2008.**

The following is an explanation of a credible allegation:

Credible allegation of compliance. A credible allegation is a statement or documentation:

- Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.
- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and
- That indicates resolution of the problems.

In order to resolve the deficiencies the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208)334-6626.

Sincerely,

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

SC/mlw

Enclosures

Hands of HOPE Hospice

* Honor * Peace * Esteem

March 26, 2008

RECEIVED

MAR 26 2008

FACILITY STANDARDS

Sylvia Creswell, Supervisor
Bureau of Facility Standards
3232 Elder St.
PO Box 83720
Boise, ID 83720-0036

RE: State Survey Credible Allegation of Compliance

Dear Ms. Creswell:

Based on the survey completed at Hands of Hope Hospice on February 19, 2008, this letter is confirming written Credible Allegation of Compliance and resolution of the problems with regards to the Medicare Hospice Conditions of Participation on Interdisciplinary Group as of March 26, 2008. For the Plan of Correction, I am providing an explanation of the changes in our systems and processes regarding each deficiency with the attached forms we are now using.

L146 INTERDISCIPLINARY GROUP
L148/L152 COMPOSITION OF THE GROUP
L155/156 ROLE OF THE GROUP

The agency's policy "Interdisciplinary Team Meeting" has been updated to include the identifiable group with the MSW to serve as the counselor (with the "IDT Meeting Minutes" form also reflecting this), how often the team will meet and how those meetings will be documented, and that the IDT group is responsible for periodic review and updating of the plan of care for each individual receiving hospice care. The MSW Job Description has been updated to reflect this change. Additionally, all policies have been dated and the policy "Policies and Procedures Guidelines" has been updated to include time frames for routine policy review and how they will be revised/updated if needed. The signature log on the "IDT Meeting Minutes" form will show IDT participation in this process.

Documentation enclosed:

1. IDT Meeting Policy
2. IDT Meeting Minutes form—now provides documentation as to the date of the conference, signatures of IDT members attending, policies reviewed/approved, policies needing revision or new policies needed. Additionally, the minutes will include a list of patients reviewed, and where the documentation of the discussion can be found (ie. Patient Review/Update form or Recert. Form) We also included a section on Deceased patients to document completion of the Death Summary/Risk Assessment.

1379 E. 17th St. Idaho Falls, ID 83401
Ph: (208) 523-7441 Fax: (208) 542-0528

3. IDT On-going Conference Dates form—will help provide a quick check to look at dates of conferences to ensure that all patients are reviewed at least monthly as our policy states.
4. IDT Patient Review/Update form—correlates with the Plan of Care. As the POC is reviewed, the correlating area on the Review form will allow us to document the current status of the patient and any changes needed the the POC.
5. Patient Review/Update Policy
6. Recertification Summary Policy
7. Policies and Procedures Guidelines Policy
8. Job Description of MSW
9. Job Description of Counselor
10. Revised POC which is more detailed to guide discussions and correlates with Patient Review/Update form.

We are excited about the changes that we have made and appreciate your help in improving our processes. If you have any questions, please contact me.

Sincerely,

Jill Garrett, RN
Hands of Hope Hospice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131547	A. BUILDING _____ B. WING _____	C 02/19/2008

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HANDS OF HOPE HOSPICE	**1379 EAST 17TH STREET IDAHO FALLS, ID 83401**

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L 000	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation survey of your hospice. Surveyors conducting the investigation were: Acronyms used in this report include: BFS = Bureau of Facility Standards IDT = Interdisciplinary Team MSW = Medical Social Worker POC = Plan of Care RN = Registered Nurse	L 000		
L 146	418.68 INTERDISCIPLINARY GROUP The hospice must ensure that specific interdisciplinary group requirements are met. This CONDITION is not met as evidenced by: Based on review of policies and IDT minutes and staff interview, it was determined the hospice failed to have an identifiable interdisciplinary group (L148); failed to ensure the IDT included a pastoral or other counselor (L152); failed to periodically review and update patients' Plans of Cares (L155); and failed to review and revise policies that governed the provision of hospice care and services (L156). The cumulative effect of these systemic practices resulted in the lack of an interdisciplinary group to monitor patient care and update patient care plans.	L 146	See attached letter	
L 148	418.68(a) COMPOSITION OF GROUP The hospice must have an interdisciplinary group or groups that include individuals who are employees of the hospice. This STANDARD is not met as evidenced by: Based on review of policies and IDT minutes and staff interview, it was determined the hospice	L 148	See attached letter	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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L 148	Continued From page 1 failed to have an identifiable interdisciplinary group. No documentation was present that an IDT, including a physician, RN, an MSW, and a counselor had met in 2007 or 2008. No evidence was present that an IDT participated in the care of 4 of 4 patients (#s 3, 12, 21, and 22) whose records were reviewed for IDT participation. The findings include: 1. The only policy defining the IDT was titled "Interdisciplinary Team Meeting and Patient Review Update". It was not dated. It stated, "An IDT is composed of representatives from at least the following areas: a-Medical Advisor b-RN c-MSW d-Aide" The policy did not address how the counselor role would be fulfilled as required at 418.68(a,4). The administrator, interviewed on 2/22/08 at 10:10 AM, stated the MSW acted as the counselor. However, she said this was not documented in policy and said the MSW's job description did not identify the social worker as the counselor for the IDT. Also, the IDT policy did not state how often the team would meet or how those meetings would be documented. 2. The Administrator was interviewed on 2/14/08 at 3:25 PM. She stated the team met on Wednesdays but stated these meetings were often not documented. She stated minutes of these meetings were not kept. She presented dated lists of patient names which she said had been discussed at IDT meetings. There were 7 lists dated between 7/12/07 and 2/1/08. No lists were dated for December 2007 or September	L 148	See attached letter	

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L 148	Continued From page 2 2007. One list was not dated. The lists were of patient names. Lists included names and a space for comments. The lists did not discuss POCs. They included brief comments. For example, the list dated 2/1/08 contained Patient #22's name and stated "Belly button". The list dated 1/2/08 stated "Not going out, getting dressed" for Patient #21. The 2/1/08 list contained comments for only 6 of 41 names. Some names were a first name and last initial. No documentation was present identifying this as an IDT meeting, stating who attended while this form was filled out or if this was the result of an IDT meeting. The administrator stated the other way meetings were documented was through "IDT Patient Review/Updates", which were present in patient records. These were very minimal. On 2/20/08 at 10:30 AM, surveyors requested the Administrator provide IDT Patient Review/Updates for Patients #3 and #12. Both patients had received hospice services for the entire year 2007. Patient #3 had only 2 IDT Patient Review/Updates for 2007, dated 9/11/07 and 11/13/07. Patient #12 also had only 2 IDT Patient Review/Updates for 2007, dated 8/14/07 and 10/23/07. These forms did not document that the IDT had met, only that an RN had filled out the form. The administrator stated, on 2/2/08 at 10:10 AM, that she did not have actual documentation of any IDT meeting in 2007 or 2008. While the IDT policy stated a group was in place, there was no record that they had met or conducted any business on behalf of the hospice in 2007 or 2008.	L 148		
L 152	418.68(a)(4) COMPOSITION OF GROUP The hospice must have an interdisciplinary group or groups that include a pastoral or other counselor.	L 152	See attached letter	

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L 152	Continued From page 3 This STANDARD is not met as evidenced by: Based on reveiw of policies and IDT minutes and staff interview, it was determined the hospice failed to ensure the IDT included a pastoral or other counselor. The findings include: 1. The only policy defining the IDT was titled "Interdisciplinary Team Meeting and Patient Review Update". It was not dated. It stated, "An IDT is composed of representatives from at least the following areas: a-Medical Advisor b-RN c-MSW d-Aide" The policy did not address how the counselor role would be fulfilled as required at 418.68(a,4). The administrator, interviewed on 2/22/08 at 10:10 AM, stated the MSW acted as the counselor. However, she said this was not documented in policy and said the MSW's job description did not identify the social worker as the counselor for the IDT.	L 152		
L 155	418.68(b)(3) ROLE OF GROUP The interdisciplinary group is responsible for periodic review and updating of the plan of care for each individual receiving hospice care. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the hospice failed to ensure that the interdisciplinary group was responsible for periodic review and updating of the plan of care for 4 of 4 patients (#s 1, 3, 11, and 12), whose records were reviewed for care planning. The findings include:	L 155	See attached letter	

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L 155	Continued From page 4 The agency's policy titled "Interdisciplinary Team Meeting and Patient Review /Update", undated, stated a "Patient's care plan will be reviewed a minimum of once every month" and "Each discipline attending is required to update POC (Plan of Care), as appropriate." Documentation of the IDT updating POCs was not present in clinical records. Examples include: * Patient #1 was an 83 year old female admitted to the hospice on 2/23/07 with a diagnosis of end stage dementia. She was a current patient on 2/14/08. The patient's record contained two "IDT Patient Review/Update" forms, dated 3/27/07 and 4/24/07. The "IDT Patient Review/Update" form, dated 2/23/07, did not document a need to update or change the POC. The "IDT Patient Review/Update" form, dated 4/24/07, documented the patient had "uncontrolled" pain in her legs that required a new medication. The section of the patient's POC regarding pain was not updated, on 4/24/07, to reflect her "uncontrolled" leg pain. The record did not contain "IDT Patient Review/Update" forms dated after 4/24/07. The record did not contain evidence that the IDT discussed the patient's failing health or reviewed the POC to ensure that it continued to address and meet the patient's needs after 4/24/07. * Patient #11 was an 85 year old female admitted to the hospice on 6/8/07 with a diagnosis of end stage Alzheimer's Disease. She expired on 10/6/07. The patient's record contained one "IDT Patient Review/Update" form dated 7/24/07. The form did not document a need to update or change the POC. However, notes contained on the form documented the patient had increasing urinary incontinence, was unsteady when	L 155		

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L 155	Continued From page 5 ambulating and had difficulty expressing herself. The record did not contain "IDT Patient Review/Update" forms dated after 7/24/07. The record did not contain evidence that the IDT discussed the patient's failing health or reviewed the POC to ensure that it continued to address and meet the patient's needs after 7/24/07. * Patient #3 was an 84 year old female admitted to the hospice on 8/13/05 with a diagnosis of pulmonary fibrosis. She was a current patient on 2/14/08. Patient #3 had only 2 IDT Patient Review/Updates for 2007, dated 9/11/07 and 11/13/07. The POC did not document any changes in conjunction with these dates and no substantive changes were apparent on the POC. A box on the POC, labeled "Care Plan Update", contained only 3 dates when the plan had been changed since the patient was admitted. These boxes contained only a day and month so it was not possible to tell in which year they occurred. The administrator stated, on 2/2/08 at 10:10 AM, that she did not have actual documentation of any IDT meeting in 2007 where the POC was discussed and updated. * Patient #12 was an 87 year old female admitted to the hospice on 12/6/05 with a diagnosis of debility. She was a current patient on 2/14/08. Patient #3 had only 2 IDT Patient Review/Updates for 2007, dated 8/14/07 and 10/23/07. The POC did not document any changes in conjunction with these dates and only one change was apparent on the POC when physical therapy was discontinued. A box on the POC, labeled "Care Plan Update", contained only 2 dates when the plan had been changed since the patient was admitted. These boxes contained only a day and month so it was not possible to tell	L 155		

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L 155	Continued From page 6 in which year they occurred. The administrator stated, on 2/2/08 at 10:10 AM, that she did not have actual documentation of any IDT meeting in 2007 where the POC was discussed and updated.	L 155		
L 156	418.68(b)(4) ROLE OF GROUP The interdisciplinary group is responsible for establishment of policies governing the day-to-day provision of hospice care and services. This STANDARD is not met as evidenced by: Based on staff interview and review of the hospice policy manual, it was determined the hospice failed to ensure the interdisciplinary group (IDT) was responsible for establishing, reviewing and revising the policies that governed the day-to-day provision of hospice care and services. No evidence was present that the IDT reviewed or approved agency policies. The findings include: 1. The policy "Policies and Procedures Guidelines", undated, listed the following as responsibilities of the IDT: "Hospice policies and procedures are developed and written by the hospice owners, as the governing body, in conjunction with the IDT members. If policies are found to be outdated or in need of revision, the IDT team will collaboratively revise and institute the revisions. If new policies are needed for changes/new requirements, or new procedures, they will be written and reviewed by the IDT team." The policy did not give time frames for policy review or state how processes would be identified for review or update.	L 156	See attached letter	

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L 156	Continued From page 7 2. Surveyors requested a list of all policies reviewed and updated by the IDT in 2007 and 2008. On 2/20/08 at 6:30 PM, the administrator faxed the following policies and procedures to surveyors: "Patient Education - Materials for Patients/Families", "Revised 1/10/08 by IDT" "Patient Rights and Responsibilities", "Revised 1/10/08 by IDT" "Care of PICC, Portacath, SQ sites", "Revised 6/15/07 by IDT" "Comfort Packs", "Revised 1/20/07 by IDT" The administrator, on 2/22/08 at 10:10 AM, stated the agency did not maintain a signature log or minutes of IDT meetings to verify that the group discussed the above policies or procedures. Even though the policies contained the statement that they had been revised by the IDT there was no evidence provided by the administrator that the IDT had actually reviewed and revised the policies. Additionally, the administrator documented on the fax that the IDT had not been doing "routine" policy review.	L 156		